

YOUTH-SIZED LAB COATS

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YOUTH-SIZED LAB COATS: WHEN CHILDREN BECOME DOCTORS THROUGH
ADOLESCENT HEALTHCARE BROKERING

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Research Proposal

This research project will dive into the child language brokering phenomenon and the specific occurrence within healthcare, adolescent healthcare brokering, from an inclusive perspective. As a relatively new and emerging research subject, present findings only begin to scratch the surface of understanding where, why and how child language brokering takes place, along with the long-term effects on those involved; however, I expect to find much of the existing research proving that there is a time and place for child language brokering and healthcare is not one of those places. After weighing the positive and negative impacts, I expect to argue against it occurring in the medical setting. My paper will advocate for the implementation of strategies to support and protect vulnerable parties involved in adolescent healthcare brokering, including the children themselves.

How the Project will be Accomplished

A conversation with my mother sparked the idea for my topic. She is a high school teacher who runs the local AVID (Advancement Via Individual Determination) program, an academic support course for traditionally first-generation college-bound students, many of whom are from minority or lower income backgrounds. The class provides study tools, skills for success and an open, understanding environment to foster relationships with similar students. This conversation was about one of her students and how overwhelmed she was trying to catch up on schoolwork after spending weeks translating for both grandparents at numerous doctors' appointments. She found it difficult to balance the demands of her academic course load and the emotional baggage from focusing on weeks of sensitive and heartbreaking translations.

After hearing this story, I began to wonder why children are used to translate potentially traumatic medical information for their loved ones, when that is not the case for native English

speaking families. Growing up, I almost never attended any of my parents' appointments, nor was I asked to give them the doctor's diagnosis when I did. I could never have imagined being asked to break the news of a cancer diagnosis to a loved one, so why do familial translators have to carry that burden?

My research is guided by the following questions:

1. Why are there different institutional standards set for immigrant and native children? Is there a point at which content is deemed inappropriate for a child translator? If not, what would this process look like?
2. Are there laws in place about the right to a professional translator within institutions like hospitals? Are these services offered immediately and/or free of charge? If there are, why are child language brokers still being used in their place?
3. How does a doctor (or other professional) decide when to use a professional or familial translator? Whose decision is this and is that consistent with whose decision this should be?
4. What are the short- and long-term effects of child language brokering for high-stakes situations on the children involved? How can we better protect the children in these cases?
5. If some form of child or familial language brokering has been occurring for centuries, why is it only recently gaining research attention? What does the previous lack of attention say about the target population involved?

Due to the difficulties of accessing the involved populations, sensitive subject matter, confidentiality issues, availability of research funds and project time constraints, this paper will

be primarily conducted as a literature review and synthesis of existing material. I will aim to find research focusing on every possible perspective of those involved, from children, to parents, to healthcare providers; if I notice there is a gap in the narrative, I will try to call attention to this as an area for future study, along with critically analyzing why this gap may exist.

Significance of Research

The intention of this paper is to provide a comprehensive source of the key findings from existing literature on adolescent healthcare brokering. I believe many sources will present various benefits and drawbacks from brokering, along with valuable anecdotal experiences, with an underlying sentiment that there are no formal guidelines in place for using children as translators. From there, my hope is that it can serve as a resource to promote institutional changes to create a more accommodating and equitable healthcare system.

How this Project Connects to my Discipline

Though there are no set rules requiring or resources teaching it, child brokering seems to occur similarly around the world among immigrants from various backgrounds. The cultural views on family must be inherent to establish a child broker position and deeply connected to innate survival skills once living in an unfamiliar country. There seem to be a set of unspoken social norms in place to manage the interactions and relationships between speakers and translator. As evidenced by the lack of previous attention, this topic brings to light experiences unique to immigrant and multilingual communities.

How this Project Relates to my Future Career

After graduation, I will be attending Nursing school, with the intention of working in California. As California is known for having a large immigrant and multilingual population, it is crucial for me to understand the environmental and situational factors surrounding all of the

communities I will serve. I believe that having a deeper understanding of adolescent healthcare brokering will benefit me in my future career. With this knowledge, I can help promote a safe, equitable and comfortable healthcare experience for everyone involved. If I ever come across an adolescent healthcare broker in my career, I will know how to better support the child and patient.

Annotated Bibliography

Antonini, R. (2010). The Study of Child Language Brokering: Past, Current and Emerging Research. *MediAzioni*, 10, 1-23. Retrieved February 28, 2019, from <http://mediazioni.sitlec.unibo.it/index.php/no-10-special-issue-2010/162-the-study-of-child-language-brokering-past-current-and-emerging-research.html>

This article provides an overview of the special volume of the journal, featuring a collection of research and studies on child language brokering by scholars from around the world. Each article presents a unique experience and analysis of child language brokering from within various fields and from different research methods. This article specifically discusses the history of general language and culture brokering, while providing comparisons between professional and nonprofessionals in the field; it also provides an inside perspective from multiple different countries. Because of the evidence collected that child language brokering happens worldwide, it proves the importance of advancing research on this phenomenon. The University of Bologna at Forlì hosted a “Study Day on Child Language Brokering,” creating a platform for institutional representatives and former child language brokers to discuss and compare their experiences. After the event, they realized how relevant and related all of the participants’ experiences were, they chose to dedicate a special volume of their journal to dive deeper into the study and analysis of child language brokering as an emerging field of study. This article has a fairly open perspective when discussing the history and current research on child language brokering. The research has been gathered from various different countries and perspectives, so investigates with a holistic approach. It references sources that highlight both the stresses and enjoyable experiences a child may have, and acknowledges the need for further exploration. I believe the underlying philosophy is the overall importance of a continuation and deepening of the research already present because of the critical findings that have been made and are yet to be made. This article and subsequent journal volume provide invaluable material regarding the current practices and experiences within child language brokering across a multinational platform. This article specifically can inform my research from a historical background of general culture and language brokering, along with the emerging research from a global level that will give me a wider understanding of this phenomenon in other countries. For the most part, this article will be a jumping off point for the rest of my research, as it provides multiple other resources that can benefit my paper. (361 words)

Banas, J. R., Wallis, L. C., Ball, J. W., & Gershon, S. (2016). Adolescent Healthcare Brokering: Prevalence, Experience, Impact, and Opportunities. *Journal of School Health*, 86(12), 898-905. doi:10.1111/josh.12456

The authors coin the phrase “adolescent healthcare brokering” to explain the phenomenon of child language brokering within the healthcare setting. The results of their study are incredibly useful to my paper. They found that over half of their respondents assisted their parents with healthcare-related situations, ranging from translating communications with the doctor to doing research on conditions and medications. Many of the students showed disengagement from school and sought real-world education, “wanted to learn about filling out insurance forms and talking to doctors” (Banas et al. 898). The researchers aim to collect information about every aspect of healthcare brokering, the overall impact it has on the students involved and the support

they wish they had. To collect the data, the researchers collected survey responses from 159 students and performed a quantitative analysis of the results in SPSS. This article has an emphasized perspective on the impact of brokering within the healthcare setting. There is no clear bias toward the benefits or consequences, as they appear to neutrally present their results. I believe that this is arguably the most important source for my paper, as it is specifically focused on my research topic. This article has given a name to my primary research focus: adolescent healthcare brokering. (206 words)

Bucaria, C., & Rossato, L. (2010). Former Child Language Brokers: Preliminary Observations on Practice, Attitudes and Relational Aspects. *MediAzioni*, 10, 239-268. Retrieved February 28, 2019, from <http://mediazioni.sitlec.unibo.it/index.php/no-10-special-issue-2010/168-former-child-language-brokers-preliminary-observations-on-practice-attitudes-and-relational-aspects.html>

This article discusses the findings from the researchers study on former child language brokers and how their experiences have impacted their overall development in terms of feelings, relationships and perspectives. They specifically highlight the Italian experience and offer a deeper insight to be used by future researchers when trying to understand the phenomenon from an inside source. The researchers used a mix of interviews, focus groups and questionnaires to obtain their data. They collected their information from high school and university students. Their participants were between 16 and 27 years old. The students were found through direct contact or volunteering to participate; the focus group participants were from a specific high school that is known for having a high number of immigrant students. The students were a mix of former and current language brokers, which the researchers identify as a possible cause for varied responses within the data. The researchers seem to have a relatively neutral perspective of child language brokering as a whole, other than their understanding that it is an important phenomenon to study. Their sample was collected from an age group that was either very recently or still actively involved in acting as a broker for their families, which could result in biased results. If they had also collected data from an older sample, such as young adults who were multiple years separated from their brokering, they might have appeared less biased. This source will provide an insider perspective for my paper and will loan me valuable anecdotes to supplement my study. While slightly inconclusive, their research provides further questions for me to investigate. They questioned whether the time of immigration and in-country school attendance would have an impact on the amount of child language brokering; from here, I can look more in depth on the age and time of immigration in relation to frequency of brokering. (310 words)

Castañeda, A. (1998). Language and Other Lethal Weapons: Cultural Politics and the Rites of Children as Translators of Culture. *Chicana/o Latina/o Law Review*, 19(1), 229-242. Retrieved March 3, 2019, from <https://escholarship.org/uc/item/77v9h2cf#main>.

This article uses interviews with school-aged children to highlight some of the serious and mature content that children are responsible for translating, from struggling to explain traumatic medical conditions, to asking for credit at a store to buy milk for a baby, to facing men with guns hunting family members. The article discusses the phenomenon of how children came into these roles through exploring the history of modern American immigration. She uses historical records

and interviews to fuel her research on the “social history of Tejana farmworkers,” in which she discusses the past waves of US immigration through surges from the Bracero Program and Operation Wetback (Castañeda 233). The author implies bias against the use of child language brokers for very sensitive and potentially traumatic or stressful mature situations. She presents historical evidence of the harsh conditions for migrants during the immigration period and the overall impact of decades of recurring oppression. However, she does briefly acknowledge the existing benefits of child language brokering. Castañeda believes that the translation often happens in stressful situations, which often has long-lasting traumatic effects. This article will provide valuable anecdotal quotations and stories for my research paper, along with a historical background for reference. (200 words)

Kam, J. A., & Lazarevic, V. (2013). The Stressful (and Not So Stressful) Nature of Language Brokering: Identifying When Brokering Functions as a Cultural Stressor for Latino Immigrant Children in Early Adolescence. *Journal of Youth and Adolescence*, 43(12), 1994-2011. doi:10.1007/s10964-013-0061-z

This article analyzes how child language brokering affects the mental health and risky behaviors of those children. They begin by explaining the current multilingual culture of the United States and an overview of the existing known positive and negative aspects of child language brokering. They discuss the subjective, descriptive and personal norms and their relationship with the outcome of the children. They use information gathered from numerous sources from previous studies and research to present a general summary of the existing findings. The researchers conducted a longitudinal survey of 234 middle school Latino students that have been involved with child language brokering; by using a longitudinal survey, they challenge existing research based on cross-sectional data, allowing the findings to be tracked over time. The surveys asked questions about their mental health status and participation in risky behaviors, such as alcohol and drug use. They appear to show a bias towards the significance of the relationship between acculturated stress, sentiment towards brokering and mental health and unhealthy behaviors. However, they do acknowledge the statistical significance or lack thereof from their findings, along with the general complexity of the phenomenon. The researchers explicitly say their hypothesis is that the more positive language and sentiment there is around brokering, the more these norms can act as a protective factor. This article can provide me with a collective list of many pros and cons of child language brokering, along with situations in which it becomes a cultural stressor. I can also use the longitudinal data from the Latino children in potential contrast or comparison to children from other cultures within my paper. (268 words)

Mcquillan, J., & Tse, L. (1995). Child language brokering in linguistic minority communities: Effects on cultural interaction, cognition, and literacy. *Language and Education*, 9(3), 195-215. doi:10.1080/09500789509541413

This research aims to look at child language brokering among the linguistic minority community, as it is not nearly as commonly studied, from the perspective of former brokers. The study looks at the phenomenon “from three perspectives: (1) culture and affect, (2) cognition, and (3) language and literacy” (Mcquillan and Tse 195). By doing so, they open up the opportunity for more data to be collected to allow for a greater representation for linguistic minorities within the overall research. The article begins with a comprehensive overview of existing studies and

research to give readers context to previous common findings. The researchers interviewed nine adults between 18 and 29 years old who acted as linguistic minority child language brokers growing up. While not a longitudinal study, by talking to adults about their childhood experiences, they can see the long-term effects. A majority of their participants spoke languages within the Sino-Tibetan and Austroasiatic families and all but one of the informants immigrated to the United States during their childhood. Their focus was on the effects of brokering on the children, though they acknowledge the importance of impact on parents; this is an interesting point, as most of the research seems focused on the children's perspective. I could imagine that the parents may have a completely different experience and may be impacted by the level of dependency on their children through the role-reversal. From this source, I gathered more insight into the experiences of linguistic minority child brokers that can add to the perspectives of my research. This article also caused me to wonder about the parental thoughts of the phenomenon, as most research is primarily concerned about the effects on the children. I will try to find sources looking into the parents' perspectives to expand the depth of my paper. (300 words)

Meyer, B., & Bührig, K. (2014). Interpreting risks. Medical complications in interpreter-mediated doctor-patient communication. *European Journal of Applied Linguistics*, 2(2), 233-253. doi:10.1515/eujal-2014-0010

This article discusses the communication of risk information within the medical field from both doctors and interpreters. They found that risk information is typically expressed as an obligatory statement that must be briefly mentioned, as opposed to critical information a patient might want to consider. The authors begin their paper with the present status of multilingualism within German hospitals. They acknowledge that research has previously revealed that ad-hoc interpreters are used even with the presence of free professional interpreters. Despite the amount of multilingual patients seen in German hospitals, the quality and legal rights of patients are not always prioritized. The authors describe each type of risk information that legally and procedurally must be communicated to the patients. The sources are gathered from a various existing research, along with old transcripts they collected from doctor-patient interactions ten years prior from a previous research project, the corpus Dolmetschen im Krankenhaus (DiK - Interpreting in Hospitals). The authors present the information rather neutrally, but advise that ad-hoc interpreting should not be used in all cases. They lead with the general idea that risks are socially constructed, which is something that I hadn't realized before; it makes sense however, because we assign a negative or undesirable meaning to the things we perceive as risks. They acknowledge that the perceptions risks are different among cultural experiences and life perspectives. These transcripts were published in an article I previously included in my annotated bibliography, so if anything, this article may provide a condensed, more critical set of dialogue and findings from the main source. (258 words)

Meyer, B., Pawlack, B., & Kliche, O. (2010). Family Interpreters in Hospitals: Good Reasons for Bad Practice? *MediAzioni*, 10, 297-324. Retrieved February 28, 2019, from <http://mediazioni.sitlec.unibo.it/index.php/no-10-special-issue-2010/166-family-interpreters-in-hospitals-good-reasons-for-bad-practice.html>

This article focuses on child language brokering within the German healthcare system. This article looks into the transitional issue in other countries, such as the United States, and what

solutions they have found to tackle the problem. They discuss that although communication barriers are framed as a “transitional issue,” the practices put in place reveal that it spans much longer than any normal transitional period. The authors highlight benefits of language brokering from various other studies and researchers, along with the embarrassments and problems. The researcher’s studies are based on “transcriptions of interpreter-mediated interactions in hospitals and socio-demographic data from the German socio-economic panel.” (Meyer 297). They mainly synthesized the data collected from other studies. The German socio-economic panel, or SOEP, is a household census-type survey that collects an array of data from a representative population of Germans, including foreign-born Germans. The survey is not strictly about language and communication but asks quite a few questions that benefit the research on child language brokers. The researchers seem to be biased against child language brokering, but present both sides to the phenomenon. They present their material in a contrasting, yet contradictory, manner. It seems most of the pros of brokering are spoken of in terms of general brokering, whereas the cons are mainly found within specialized brokering, especially within the medical field. I’m not sure if that is due to consistent data proving there is more harm than good using child language brokering for pertinent and specialized cases or if it is a result of a biased group of authors, so I will need to continue looking into this. In the conclusion, they reveal that they believe all participants involved can benefit from familial language brokering, but it is important to consider the usage on an individual, case-by-case basis to avoid more potential problems. I think this article offers a unique look into child language brokering in Germany through a synthesis of various studies. It also provides a small comparison between other countries, which can give me a lead on studies and policies in the United States and other countries that may be beneficial for furthering my research. From this article, I can gain information from a collection of studies showing the benefits and problems of language brokering on a general and medical-specific range. Because I was able to find so many valuable quotations and it used resources from many outside studies, I believe this will be one of my key sources for my paper. From this article, I may decide to expand the topic of my study to general language brokering if I continue to find more information about general language brokering instead of child language brokering in the medical field. (451 words)

Rosenberg, E., Leanza, Y., & Seller, R. (2007). Doctor–patient communication in primary care with an interpreter: Physician perceptions of professional and family interpreters. *Patient Education and Counseling*, 67(3), 286-292. doi:10.1016/j.pec.2007.03.011

This article discusses the researchers’ study on the differences between doctor-patient communications with either professional or familial interpreter, along with the physician’s overall perceptions of the interactions. They found that the doctors believed that it was easier to work with the professional interpreters because it was more frequent for the family translators to have their own agenda; some of the doctors worried that their treatment would be ignored or misinterpreted to fit the familial interpreter’s agenda, though they did offer an additional perspective. Another common response from physicians was a feeling of exclusion, as the patients began experiencing the listener/sympathizer relationship with their translator instead of the doctor. They found that though physician’s believed patients would prefer to disclose private information to a professional interpreter, “patients from very small immigrant communities where most people know each other preferred to divulge health information to a family member” (Rosenberg 289). There were many instances of common sentiments from the physicians studied,

which might be reflective of a similar sentiment among a larger population of doctors. The researchers used the “stimulated recall method,” which allowed the doctors to review their appointment and comment on their thought process. The physicians met with patients and conducted appointments in both English and French (one of which they spoke less than their native language) and each appointment had either a family or professional acting as an interpreter. This article is biased towards the physician’s experience, but still portrays both the positive and negative aspects of each type of interpreter. I can use this article to have a more inclusive and holistic approach in my research. From here, I can extract valuable insight from the physician’s point of view, giving depth to my paper and explore another perspective of this phenomenon. (295 words)

Tse, L. (1996). Language Brokering in Linguistic Minority Communities: The Case of Chinese- and Vietnamese-American Students. *Bilingual Research Journal*, 20(3-4), 485-498. doi:10.1080/15235882.1996.10668640

This study seeks to investigate child language brokering among Chinese- and Vietnamese-American students, as it is not as frequently studied. The author begins her article with a brief overview of the existing research, through a literature review. Most of the articles she discusses are about general child language brokering or Spanish-speaking occurrences; she does refer to one of her previous works with another author in which they studied Asian American brokers. She surveyed 64 language minority students, asking various questions including self-reported language abilities, if they have performed language brokering and their sentiments towards having done so. She presents all of her results in tables to allow for easy comprehension of her data. This study presents new information to the collection of existing studies, as she focuses on the prevalence with language minority, or LM, communities. Her results reveal that this phenomenon is likely just as common as within other non-native communities and provides suggestions for further research. This article will give me valuable insight into the prevalence of child language brokering within Asian American and language minority communities. Having that perspective is especially important, as I am trying to take a holistic approach with my paper to represent this phenomenon as accurately as possible. (205 words)

Outline

- I. Introduction
 - A. What is child language brokering?
 - 1. Definition
 - 2. Settings it occurs
 - B. Significance of research
 - 1. Global phenomenon with limited research
 - 2. Future Implications
 - C. Purpose of my research
 - 1. Why study child language brokering?
 - 2. Definition of key terms and age ranges
 - D. Overview of paper
 - 1. What I'm studying specifically
 - 2. How my paper will be constructed
- II. The impact of immigration on families
 - A. Brief overview of immigration
 - 1. Global scale and modern reasoning
 - B. Acculturation
 - 1. Language acquisition
 - a) Children learn second language much faster than adults
- III. United States policies in place regarding non-native English speakers
 - A. Executive Order 13166
 - 1. What this establishes for limited English proficiency communities
- IV. Child language brokering in general
 - A. Benefits of general child language brokering
 - 1. Independence as children often don't involve parents if they don't have to
 - a) Signing paperwork and helping siblings, often to make it easier on their parents
 - 2. Maturity as children are directly involved adult situations
 - a) Potentially needed to translate mortgage, legal and medical information
 - b) Involved in situations typically deemed inappropriate for native-language-speaking children
 - (1) Ex. Child asking for credit at store to buy food family cannot afford or dealing with law enforcement
 - 3. Increased language acquisition skills
 - a) Including specialized terminology (ex. medical terms)
 - b) Learn second language faster as they are forced to immerse themselves in the new language

4. Tighter and more trusting relationships with parents, family and/or community
 - a) They are often very reliant on the child for most forms of communication
 - b) Bond forms through intimate translations
 5. Deeper connection to and appreciation and understanding of native language and culture, along with language and culture of residence
 - a) Have to act as linguistic and cultural brokers
 - b) Allow them to remain practicing both native and dominant languages and cultural practices
- B. Drawbacks of general child language brokering
1. Parental Language Acquisition
 - a) If parents are able to use their children as interpreters, they reduce the urgency to learn the language themselves
 - b) Parents experience isolation from the new culture and community
 - c) This creates a pattern of long-term dependency
 2. Stress and mental health effects
 - a) Situations can be traumatic, topics are often very mature or serious and cause students extra stress
 - b) High levels of nervousness and fear of messing up
 - c) Forces children to take on parental role, mediate tone and make adult-level decisions
 3. Risky behavior
 - a) Negative feelings toward brokering causes higher risk for drug and alcohol use at a young age
 4. Academic effects
 - a) Students are reporting having to prioritize brokering over classes and homework
 - b) Effects on grades
 5. Social effects and the feeling of social isolation
 - a) Students feel as if they cannot relate or talk to peers about brokering tasks
 - b) Students feel ashamed of parents and embarrassed to invite friends over
- V. Adolescent healthcare brokering
- A. Existing laws regarding medical translators
1. Title VI of the Civil Rights Act
 - a) Section 92.4
 - b) Section 92.8
 - c) Section 92.201

2. Why is this not always enforced?
3. Consequences for not enforcing?
- B. Familial versus professional interpreters
 1. Why healthcare professionals may prefer using one or the other
 - a) Speed of the interaction
 - (1) Professional translator has to relay every bit of information between patient and doctor
 - (2) Family translator can fill in the gaps with own knowledge from previous experience from living with the patient, often cutting down time by not including the patient in the interaction
 - b) Comfort level of patient and physician
 - (1) Patient may feel more comfortable with family member or professional, situationally and on an individual basis
 - (2) Physician may feel more comfortable using a family member because it feels like they have more control
 - c) Interpreter accuracy
 - (1) Familial interpreter may not understand medical terminology but know more about the patient
 - (a) However, they might not know everything or the patient may feel uncomfortable and leave out important details
 - (2) Professional interpreter is trained in medical terminology in both languages and has no personal connection to the patient
- C. Benefits of adolescent healthcare brokering
 1. Institutional understanding
 - a) Learn medical information and processes important for their future
 2. Healthcare connections
 - a) They may be seen as role models or mentors, potentially influencing career decisions
 3. Personal insight
 - a) Provide extra witness into patient health and history
- D. Drawbacks of adolescent healthcare brokering
 1. Personal agenda
 - a) Power dynamic over patient
 - (1) Interpreter doesn't have to include the patient in conversation as often
 - (2) May not fully translate conversation
 - b) Bias interference with direct translation

- (1) Family has own agenda and may not translate doctor or patient's exact words
 - (2) Ex. Father-child case with diet information
 - 2. Maturity level
 - a) Stages of development might lead children to not understand what is happening
 - (1) Ex. child thinks she caused mother's illness
 - b) Jean Piaget's stages of thought
 - 3. Seriousness of translation
 - a) Students often don't know specialized terms in either language so risk incorrect translation
 - (1) Ex. Wrong dose of medication
 - b) Severity of doctors' words may be lost in translation
 - 4. Traumatic experiences
 - a) Exposed to information their age group are usually protected from
 - (1) Ex. Telling parent diagnosis of terminal illness
 - (2) Ex. Son involved with mother's private health information
 - b) Extreme stress being the first to know with the responsibility to tell others
- VI. Furthering the discussion of adolescent healthcare brokering
 - A. Weigh benefits and risks of adolescent healthcare brokering
 - 1. Appropriate or not
 - a) What situations is it okay?
 - B. Prevalence of adolescent healthcare brokering
 - 1. Discuss global phenomenon as a whole
 - a) Findings consistent across countries
 - C. Importance of studying all perspectives of all involved
 - 1. Children (and siblings)
 - 2. Parents
 - 3. Healthcare providers
 - 4. All cultures and language minorities
- VII. Suggested solutions
 - A. Increase enforcement
 - 1. Why are the laws not being implemented as they are intended?
 - 2. Create consequences for not enforcing
 - B. Increase education
 - 1. Remind medical professionals of the laws and ways in which they need to act to be compliant
 - 2. Educate patients and children about their rights to request an interpreter
 - 3. Provide more resources so patients feel more comfortable requesting

4. Engage allies to use their natural born privilege
- C. Increase support outlets for interpreters
 1. Further development or implementation of support systems for any of the parties involved with the cultural and linguistic brokering
 2. Create community for language and culture brokers
 3. Healthcare education is beneficial to all
- D. Increase professional translators
 1. Shortages can be solved by encouraging more people to become a certified medical interpreter and educating them on how to do so
 2. Teach doctors and interpreters how to better collaborate to benefit the patient
- E. Increase standard screening process for age-inappropriate content
 1. Must be consistent with social norms and expectations for native-speaking children in same age group
 2. Examples of when it would/wouldn't be appropriate for comparison
 3. Conclusion
- A. Recap of the paper

Youth-Sized Lab Coats: When Children Become Doctors Through Adolescent Healthcare Brokering

Around the world doctors are inadvertently exploiting immigrant children while violating their protections from mental violence, language discrimination and performing harmful work granted under various articles of the Convention on the Rights of the Child (Office of the High Commissioner, 1990). Though unintentional, the use of adolescent healthcare brokers by healthcare professionals is detrimental to the health and wellbeing of immigrant and bilingual children. This paper explores the emerging study of this unique phenomenon and how to further protect those involved.

There are approximately 7,000 known languages spoken around the world; within the United States, “at least 350 languages are spoken in American homes,” and “in the New York metro area alone...at least 192 languages are spoken” (Castillo, 2015). With increasing globalization and popularization of travel, it is increasingly common for someone to experience being in a situation in which they do not speak the dominant language. In these cases, many may resort to using in-person or online translators. For families who immigrate to new countries, the parents often rely on their children to act as those translators¹.

The term “child language brokering” has been used to describe this phenomenon; though it is an emerging field of study, it has been occurring around the world for centuries. Leading specialist Lucy Tse coined the term, defining it as the use of children to “interpret and translate between culturally and linguistically different people and mediate interactions in a variety of situations including those found at home and school” (1996b, p. 226). Current research on child

¹ Though translating is commonly used to refer to written language and interpreting for spoken language, for the purposes of this paper, I will be using the two interchangeably to refer to both or either form of communication, unless otherwise stated.

language brokering refers to youth ranging from ages 3-18 years old. As this paper will later discuss, these children are called upon to perform language and culture brokering in many different places beyond home and school, including more high-stakes locations like banks, insurance agencies and hospitals.

Studying child language brokering provides a deeper understanding of language acquisition, cultural and institutional practices, family dynamics, and the overall developmental effects on the children involved. The fact that research on this phenomenon has only recently emerged and is growing rapidly is proof that the findings are valuable and necessary for expanding knowledge from the perspective of multicultural experiences.

French philosopher and social theorist Michel Foucault believed that there was a “dependence of the production of knowledge on relationships of power” (Appelrouth and Desfor Edles, 2016, p. 646). Though the traditional phrase is “knowledge is power,” Foucault challenges this, believing that the interconnected concepts could be seen flipped, as “power is knowledge.” By doing so, he reveals that knowledge is an avenue for expressing one’s power, but power can also allow for the creation of knowledge. He explains, “power appears in its most potent form when successfully translated into systems of knowledge and thus removed from reflection under the veil of obvious truths” (Appelrouth & Desfor Edles, 2016, p. 646). The lack of previous attention to this topic speaks to the history of the marginalization of immigrant communities by those in power; by studying child language brokering and adding to those “systems of knowledge,” researchers are able to give power to immigrant and multilingual communities - voices traditionally rendered unequal and invisible.

The significance of the research lies within the findings, new research questions and potential institutional policy changes. From a global perspective, researchers have found that

child language brokering is occurring in similar ways across numerous countries known for large immigrant populations. Though there is limited research available, each existing article and study acts as a call-to-action for further investigation to include additional perspectives and narratives. Hopefully the more traction that child language brokering gains, along with the support of current and future leaders in the push towards global equity, there can be a positive impact made on policies and institutions.

This paper synthesizes the existing research on child language brokering, with an emphasis on its use and effects within the healthcare system, to observe the phenomenon from a holistic and inclusive approach; it will show why this is occurring, how it is impacting the children involved and what potential solutions could be less detrimental to those involved. Child language brokering will refer to the practice of children as brokers or mediators in general settings like school, stores, banks and other personal uses. The primary focus of this paper will be on “adolescent healthcare brokering,” a term coined in 2016 by researchers Jennifer R. Banas, James W. Ball, Lisa C. Wallis and Sarah Gershon, to describe when “parents with limited English proficiency might rely on their adolescent children to interpret health information” specifically (2016, p. 739). While there are a few documented cases of younger children working as healthcare brokers in the existing research, for the purposes of this paper I will be using ages 13-18 when referring to adolescent healthcare brokering. Before discussing adolescent healthcare brokering, it is important to understand where the culture of using children as translators originated; as modern immigration began, child language brokering started to occur within more social settings and institutions outside of the home.

This paper has six sections. The first will provide a brief overview of the history of immigration and acculturation processes to provide a general explanation for the foundation of

child language brokering. The next section will discuss the benefits and drawbacks of general child language brokering. The following dives into adolescent healthcare brokering, beginning with the prevalence, current laws and a comparison with professional translators. The information on the benefits and drawbacks will be presented from the perspectives of various parties involved. This paper will end with a concluding discussion of the phenomenon and suggested institutional and political strategies that could be made to address the problems of child language and healthcare brokering.

The Impact of Immigration on Families

Global migration has been occurring around the world since the earliest humans, for reasons including adapting to climate change and following food sources and has been occurring worldwide almost non-stop since with no signs of stopping permanently (Science Insider, 2015). War-torn nations, impending prosecution and extreme poverty have also forced modern immigration, causing families to leave their homes unexpectedly, often without time to prepare for life in a new country. With a world that thrives on contributions from global perspectives, all institutions must strive to be inclusive and adapt to the needs of all populations involved, including those with whom communication might be more challenging, to ease the already traumatic transition process for the families.

The United States was a country established by and for immigrants and immigration has been occurring since its founding. According to the Pew Research Center, “the U.S. foreign-born population reached a record 44.4 million in 2017” and “more than 1 million immigrants arrive in the U.S. each year” (Radford, 2019). Historically, it has been expected that immigrants undergo the Americanization process to properly acculturate and assimilate into the United States society.

Acculturation

From a social perspective, acculturation has been the main option in terms of becoming successful post-immigration. Acculturation may include religious conversion, practicing the dominant culture and language acquisition; it must be acknowledged that historically, even Native Americans were forced to the extremes of assimilating to the colonizing culture, though the Europeans were the ones who had immigrated onto their land. When families immigrate to another country, the children are often the quickest to acculturate, as the school setting is strongly tied to the dominant culture and reinforces the language acquisition.

Because of their immersion in school, immigrant children are often exposed to the new language more frequently than their parents. Numerous studies have revealed that “bilingual language acquisition” is the easiest before one reaches puberty, primarily stemming from the neuroplasticity of young age (Karavasili 2017). For this reason, it is common for students to become more proficient in the dominant language of their new country before their parents, establishing the opportunity and necessity for child language brokering to occur. Children of foreign-born parents often serve as linguistic and cultural translators for parents, family or community members, as they are the ones first and most exposed to the language and social norms of the new country.

Support for the Limited English Proficient Community

With the occurrence of child language brokering, it might be assumed that the government condones or promotes it or that it still occurs due to a lack of better alternatives. However, the United States has policies in place to support and assist to those who may have limited or no English language comprehension such as the Executive Order 13166.

On August 11, 2000, President Clinton signed Executive Order 13166 (2000) “to improve access to federally conducted and federally assisted programs and activities for persons who, as a result of national origin, are limited in their English proficiency (LEP)” (p. 3298). It states:

The Federal Government provides and funds an array of services that can be made accessible to otherwise eligible persons who are not proficient in the English language. The Federal Government is committed to improving the accessibility of these services to eligible LEP persons, a goal that reinforces its equally important commitment to promoting programs and activities designed to help individuals learn English. To this end, each Federal agency shall examine the services it provides and develop and implement a system by which LEP persons can meaningfully access those services consistent with, and without unduly burdening, the fundamental mission of the agency. Each Federal agency shall also work to ensure that recipients of Federal financial assistance (recipients) provide meaningful access to their LEP applicants and beneficiaries. To assist the agencies with this endeavor, the Department of Justice has today issued a general guidance document (LEP Guidance), which sets forth the compliance standards that recipients must follow to ensure that the programs and activities they normally provide in English are accessible to LEP persons and thus do not discriminate on the basis of national origin in violation of title VI of the Civil Rights Act of 1964 [42 U.S.C. 2000d et seq.], as amended, and its implementing regulations. As described in the LEP Guidance, recipients must take reasonable steps to ensure meaningful access to their programs and activities by LEP persons. (Executive Order No. 13166, p. 3298)

The government has provided guidelines to assist programs in providing services that are more accessible to the LEP community. These programs may include “recipients of federal financial assistance (i.e. public or private institutions such as schools, hospitals, etc.)” and “these services may include written materials such as bilingual information sheets, signs, etc., and may involved the implementation of translation and interpreting services” (Meyer, Pawlack, & Kliche, 2010, p. 299). By establishing such guidelines, the United States government is acknowledging that there are structural and institutional barriers for those who do not speak English; by the consistent culture of using children as translators, however, it is clear that there are still gaps preventing equitable access to services for adults with limited English proficiency.

Child Language Brokering

Though it has been happening for centuries, child language brokering as a research topic is a budding phenomenon. Using data from the US Census Bureau American Community Survey, the Urban Institute found that “in 2017, 20 percent of children of immigrants lived in linguistically isolated households, meaning that no family members over age 14 were proficient in English” (Urban Institute, 2019). As best stated by researcher Vikki Katz, “while there is no way to gauge what proportion of these children broker for their families, in which locations, and with what frequency...data suggest that children of immigrants in the United States are growing up in families where parents who need assistance navigating their English-speaking environment are the norm rather than the exception” (Katz, 2014, p. 198). Most of the existing research has focused on the benefits, risks and specific occurrences of brokering.

Benefits of Child Language Brokering

As exemplified in many previous studies (citations), child language brokering can be beneficial to the children involved. By translating for others, they receive a deeper immersion into the new country’s culture and language than they would have without the extra practice, along with experiencing coming-of-age type growth and development. Child language brokering can positively impact youth by developing independence, maturity, language development, relationships and cultural appreciation.

As children were exposed to new concepts they were unfamiliar with, they might have asked their parents for help, eventually gaining a deeper grasp for the material. In a study done by researchers Mcquillan and Tse (1995), they found that “eventually, the brokers developed an understanding of certain topics (e.g. the transactions that were needed to receive government assistance) which allowed them to perform without assistance” (p. 204). The frequency of child

language brokering demonstrates that over time, the brokers feel confident in new topics and their adult-like responsibilities to the extent that they no longer need to involve their parents every time or right away. Because the parents are unable to directly participate in academic conversations with teachers or fully understand paperwork such as permission slips, one student recalled “making important educational decisions and only later informing her parents” (Mcquillan and Tse, 1995, p. 204). Multiple children reported dealing with these types of situations for themselves or for siblings without involving their parents, not wanting to worry their parents with the little things they knew they could handle. Mcquillan and Tse (1995) talked to two additional students who “mentioned often by-passing their parents when taking care of their younger siblings in such things as writing letters to school, signing notices, and contacting teachers and administrators” (p. 204). These kinds of experiences show that the brokers encompass both independence and maturity levels arguably greater than those of their peers.

Since the parents do not have a working proficiency of English, the brokers are usually required to assist in almost every aspect of their parents’ lives. With the heavier specialized subject matter that the children are exposed to, “despite lacking some knowledge in academic areas, brokers develop knowledge about the world outside of school far more sophisticated than most of their peers” (Mcquillan & Tse, 1995, p. 210). From exposure to tax documents, mortgage agreements and other complex financial and government forms from ages as young as 12 years old, researchers discovered that children who act as language brokers learn far more than the education system is teaching them (Mcquillan & Tse, 1995). By learning how to navigate these institutional spheres from an early age, they are more prepared to handle them as adults.

On top of the specialized topics they are learning about in both their native and new languages, child language brokers are fully immersing themselves into the dominant language of their new country. Leading researchers Mcquillan and Tse (1995) found that “increased language acquisition, while self-reported, is confirmed indirectly by the rapidity with which the subjects began brokering after their arrival in the United States...many subjects began brokering almost immediately upon arrival” and “in addition to increased language acquisition and the comprehension of adult-level texts, some brokers stated that their brokering experience was crucial to the maintenance of their native language” (p. 206). From constant exposure to both languages, child language brokering allows youth the opportunity to cultivate specialized lexicons and enhance development of each.

Child language brokering requires the parents to trust fully and blindly in their children. The parents must rely on their children to report information accurately, without being able to ensure that the information being interpreted to or from them is correct. The duty of child language broker often falls on the oldest child, as they were likely either the only option upon immigration or had a high level of comprehension needed to perform the task. Mcquillan and Tse (1995) found that “a certain status was accorded to the child brokers in the family, and their effectiveness as brokers in a variety of circumstances meant increased prestige among siblings, parents, and the extended family” (p. 196). The brokers often report feeling proud to perform this duty for their families and having a closer relationship to the parents for whom they act as brokers.

With a constant need to switch between languages, child language brokers often need to consider the cultures involved, interpreting those as well as the words spoken. Previous research reveals that many of these children not only said “brokering sped their acculturation into

American culture and their integration into American society” but that it also “increased general knowledge of the world and broadened cultural understanding” (Mcquillan & Tse, 1995, p. 205). From experiences at home and in public, the students were able to quickly learn where the commonalities and differences existed between both cultures, for instance, kissing both cheeks upon greeting a friend. Mcquillan and Tse (1995) remarked “high levels of sensitivity toward and broadened understanding of the first culture, together with their newly acquired knowledge of the second culture, make brokers particularly valuable sources of intercultural information and insight” (p. 207). Many aspects of child language brokering seem to have similarly valuable opportunities for students to take advantage of while helping their family members.

Drawbacks of Child Language Brokering

Child language brokering can also have detrimental effects on those involved. From children being exposed to mature content before it is developmentally appropriate to impacting the performance as a student, participating in brokering may not always be the best option. Due to the nature of the job, the mental, emotional, educational and social health of the child are at risk. Using children as linguistic and cultural brokers has the following negative effects on the children and adults that require their services.

When an adult immigrates into a new country, they often depend on the accelerated language acquisition skills of their child or the children of previous immigrants. By constantly relying on children to broker almost every interaction, there is no longer a sense of urgency for “learning and interacting with the second culture,” and many never truly learn the new language (Mcquillan & Tse, 1995, p. 205). Without having the ability to use children in this way, acquiring the language and engaging in cultural practices would be an urgent necessity for adults in their new country. With child brokers and the increased bilingual services available to those

with limited English proficiency, “language barriers are no longer regarded as transitional” (Meyer et al., 2010, p. 299). There is no longer a need for the parents to ever engage with the new language or culture, leaving more adults indirectly isolated from the dominant way of life. These parents are often dependent on their children long-term, as opposed to temporarily after immigration, which can exacerbate or create more potential problems for their brokers.

When brokers are exposed to subject matter that is far beyond their years or feel obligated to take care of their siblings, it can take a toll on their mental and emotional health. It can be argued that “translating for parents and family is harmful to the child’s psychological development and that, because children play an adult role while they are translating, they may grow up too quickly and resent or lose respect for their parents” (Castañeda, 1998, p. 236). In a study on child language and culture brokering, researcher Castañeda reflects on the aftermath of many experiences often left undiscussed:

Their oral histories reveal that the act of translation is informed by unequal power relationships. Translation usually occurs under conditions of conflict and stress. It is frequently traumatic, and the trauma is long lasting. Children are often at the center of the process of translation, and they experience that trauma more strongly than adults. What, then, do we make of children translating cultures? How do we assess, analyze, theorize, and interpret this experience, which in most cases continues into their own adulthood and generally until their parents’ death? (Castañeda, p. 236).

Castañeda points out that there is a lack of support and resources for children who are directly involved with interpreting grave subject matter. Without proper debriefing, the children are left most likely struggling with their mental health or feeling like they must conceal their emotions.

When children do not have healthy outlets for the emotional distress caused by brokering, those struggling with their duties may start to show attention-seeking behavior or turn to harmful activities to cope. Multiple studies have revealed that “among adolescent who act as language brokers, those who reported more negative feelings were at a greater risk for acculturation stress,

and in turn, alcohol and marijuana use” (Banas et al., 2016, p. 903). Regardless of whether the students are sharing these sentiments with their families, they are expressing them in risky behaviors. Similarly, the children may begin to act out at home and show disrespect toward their parents or native language or culture. With enough discontent paired with the burden of obligation, they may begin to detach from and reject their native identity entirely.

Though it may seem like a great supplement to their classroom education, children who continually need to interpret in various settings may see a decline in academic quality. As discovered in existing research, the “amount of brokering is inversely associated with academic performance, feelings of ethnic belonging, and substance use” while “lower levels of brokering were associated with greater academic performance, and higher levels were associated with the opposite” (Banas et al., 2016, p. 903). This study showed that the time spent brokering seems to directly hinder and take away from the time spent focusing on academia. As previously mentioned as my motivation for this research paper, I have seen first hand how a students’ grades had plummeted after spending weeks needing to interpret for her family. The older a broker is, the more difficult it is to catch up after time away from schoolwork.

Almost all research has revealed that a child’s brokering is not a temporary job and sometimes only ends when a child moves out, another child takes over or with the death of a parent. With some parents making little to no attempts to acculturate to the new country, they show no to signs of move away from the reliance on their children. From interviews with child language brokers, Mcquillan and Tse (1995) revealed:

Some of the negative aspects of brokering reported by the informants are added stress and burden associated with increased responsibility, which some said resulted in frustration, resentment, and embarrassment...Several subjects said that at times they felt resentful toward their parents and siblings for demanding enormous amounts of time and attention...Both Rebecca and Kim recalled feeling ashamed of their parents because they

could not speak English, especially in social situations and public places. Rebecca and Robert reported not inviting friends over to their homes because they wanted to hide their parents' lack of proficiency in English. (p. 205)

The children's social relationships are greatly impacted by their parents' limited English proficiency, which can potentially affect their relationship skills throughout their lives. If a broker feels ashamed or self-conscious about their families while they are in the critical stages of development for building relationships, it may hinder them later on in life as well. Researchers Bucaria and Rossato (2010) express that brokering "is mainly a lonesome and private experience for the child, and one that s/he tends to hold back after becoming an adult" (pg. 254). Seeing interpretation as a normal family obligation can be an isolating experience when children feel the pressured to hide it from friends. While the positive aspects of language brokering may seem very beneficial to the child, there is a greater risk for more immediate and long-term detrimental impacts.

Adolescent Healthcare Brokering

Adolescent healthcare brokering focuses on the child broker phenomenon within medical environments. These cross-lingual communications may occur during regular physician appointments, trips to the emergency department or at specialized visits in fields such as obstetrics or oncology. Physicians may play a role whether adolescent healthcare brokers or qualified interpreters are used during appointments. Though there are laws in place to prevent its occurrence, adolescent healthcare brokering continues to have both positive and negative impacts on those involved. Before examining the differences between interpreters and the effects of healthcare brokering, it is first important to understand the legal policies in place.

Existing Laws Regarding Medical Translators

Building on previous civil rights laws and policies, the Nondiscrimination in Health Programs and Activities ruling clarifies and implements section 1557 of the Affordable Care Act (ACA). The final ruling of this section was issued in 2016 (Office for Civil Rights, 2018). Despite the risk of weighing down this paper with legal terminology, it is crucial to include as this federal document proves the illegality of adolescent healthcare brokering. The following three sections of the Affordable Care Act directly address healthcare providers, establish the legal right to professional interpreters and prohibit the use of adolescent healthcare brokers.

Section 92.4 defines the specific intentions behind certain terms and phrases used in the Affordable Care Act. It defines a *covered entity*, as “(1) an entity that operates a health program or activity, any part of which receives Federal financial assistance; (2) An entity established under Title I of the ACA that administers a health program or activity; and (3) The Department,” referring to the U.S. Department of Health and Human Services (Nondiscrimination in Health Programs and Activities, p. 549). The term “qualified interpreter” is defined as someone who:

“(1) adheres to generally accepted interpreter ethics principles, including client confidentiality; (2) has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language; and (3) is able to interpret effectively, accurately, and impartially, both receptively and expressively, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology” (Nondiscrimination in Health Programs and Activities, p. 551-2)

An almost identical definition is used for “qualified translator,” except refers to the written languages, as interpreters are used for spoken and translators for written communication.

The next related section, 92.8, requires healthcare providers to increase the accessibility and access to their facility by offering services in multiple languages. It mandates “the covered entity provides language assistance services, including translated documents and oral interpretation, free of charge and in a timely manner, when such services are necessary to

provide meaningful access to individuals with limited English proficiency” (Nondiscrimination in Health Programs and Activities, p. 553). In addition, section 92.8 also requires that a statement of nondiscrimination be posted, along with a notice that patients have a legal right to a translator or interpreter upon request.

Section 92.201 is a crucial section that requires all covered entities to provide qualified interpreters and restricts the use of adolescent healthcare brokers except in extreme extenuating circumstances. The following rulings are to be enforced within all healthcare settings:

(c) *Language assistance services requirements.* Language assistance services required...must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with limited English proficiency.

(d) *Specific requirements for interpreter and translation services...*

(1) A covered entity shall offer a qualified interpreter to an individual with limited English proficiency when oral interpretation is a reasonable step to provide meaningful access for that individual with limited English proficiency; and

(2) A covered entity shall use a qualified translator when translating written content in paper or electronic form...

(e) *Restricted use of certain persons to interpret or facilitate communication.* A covered entity shall not:

(1) Require an individual with limited English proficiency to provide his or her own interpreter;

(2) Rely on an adult accompanying an individual with limited English proficiency to interpret or facilitate communication, except:

(i) In an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; or

(ii) Where the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances;

(3) Rely on a minor child to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no qualified interpreter for the individual with limited English proficiency immediately available; or

(4) Rely on staff other than qualified bilingual/multilingual staff to communicate directly with individuals with limited English proficiency. (Nondiscrimination in Health Programs and Activities, p. 556)

It is important to reiterate that this section not only mentions that interpreting services should be provided in a timely manner and at no cost, but also restricts the use of children as interpreters, apart from in emergencies in which a professional broker is not immediately available. From broker survey results, researchers found that “despite assurances that children are not permitted to interpret for their parents in a medical setting, more than 62% of the participants who broker indicate they spoke with doctors or nurses on behalf of their family members, a finding similar in a comparable communities” (Banas et al., 2016, p. 902). If this federal ruling makes adolescent healthcare brokering illegal, why is it still occurring at such frequency without any legal repercussions?

Familial versus Professional Interpreters

Perhaps part of the reason that adolescent healthcare brokering is still occurring, despite federal restrictions, is because the healthcare professionals prefer to continue using relatives to communicate to limited English proficiency patients and so do not actively advertise the patient’s legal right to a qualified interpreter. A few studies have explored the perspective of physicians’ preferences for using family members or qualified interpreters during appointments and the differences between the two. Efficiency, comfort and accuracy all play potential roles in why medical providers may prefer one type of translator to the other.

Many United States institutions have shifted towards increasing efficiency and quantity and this is especially evident in the healthcare industry. As findings from Tai-Seale, McGuire and Zhang (2007) reveal, regular physician’s appointments now last an average of fifteen minutes and adding in the factor of interpretation could create a backlog of appointments. Because a professional interpreter needs to relay information continually between the patient and physician, the physicians may prefer familial interpreters who are already familiar with the

patient's medical history and intentions. Meyer, Pawlack and Kliche (2010) found that familial interpreters were informed enough about the patient's condition, which benefited the physicians and allowed them to talk "without integrating the patient into their communication" (p. 311-12). This cut down the time spent between repeating every sentence in both languages, increasing appointment efficiency. Physicians may not advertise the patient's right to a qualified interpreter because the family member is a convenient alternative to the time-consuming process that requesting and using a professional would entail.

One of the major differences found between using familial and professional interpreters was the level of patient comfort. Researchers Rosenberg, Leanza and Seller (2007) examine their findings after discussing doctor-patient interactions after appointments:

Many physicians believed that patients were prepared to disclose aspects of their life to professional interpreters (obliged to maintain confidentiality) that they were reluctant to reveal to a family member...Patients from very small immigrant communities where most people know each other preferred to divulge health information to a family member. (p. 289)

Given the reason for the appointment or familial relationships, patients may feel more comfortable with one interpreter over the other. When given the opportunity, the use of familial or professional interpreters may simply be dependent on the patient's preference from both a situational and individual basis. The physician comfort may also be a reason adolescent healthcare brokering may be used. Interviews found that "physicians felt the loss of what makes them healers, their symbolic power, as the information went through a third person and into another language" (Rosenberg et al., 2007, p. 290). If professional interpreters interfere with the physician's perceptions of their value as a caregiver, they may be less inclined to suggest it to their patients.

Another reason why either the familial or professional interpreter may be used could be related to the accuracy of the messages relayed. Because of a potential lack of the medical lexicon, the familial translator may not understand or relay the words as perfectly as a trained professional might. While the professional interpreter may be skilled in medical terminology, they are less versed in the cultural and personal background of the patient. Additionally, interviews revealed “physicians were particularly concerned about the accuracy of the information they might obtain via a family interpreter concerning sensitive and/or taboo subjects” (Rosenberg, Leanza & Seller, 2007, p. 289). Due to the personal connection, the patient may not reveal intimate details to their familial interpreter. Weighing the options with either interpreter, the physicians may be deciding that child healthcare brokers prove the better option overall, resulting in the continued usage against federal regulations.

Benefits of Adolescent Healthcare Brokering

Additionally to those seen with child language brokering, there are a few positive impacts of adolescent healthcare brokering. These benefits may be reaped by the broker upon entering adulthood or may come in handy during doctor-patient interactions. The adolescent has unique access to the medical field, learning about the inner workings and forming relationships, but also provides relief to their parents and the healthcare providers.

Once they become familiar with the medical system and language, adolescent healthcare brokers are able to gain valuable insight into the healthcare system. This rare opportunity expands beyond that of the non-brokering adolescent and what is taught in formal education. This advanced knowledge of the ways in which this complex institution functions and experience navigating it will ease their transition into adults in charge of their own medical interactions.

Healthcare brokers form relationships with more medical professionals than most children their own age. These professionals can serve as additional role models and potentially mentors or inspirations throughout their lives. Though participation as an adolescent healthcare broker, they are subconsciously exploring careers in both medicine and professional medical interpreting.

Another benefit that adolescent healthcare brokers provide is a unique perspective into the daily life of the patient that physicians usually do not get to see. Physician interviews support this and as one explained, “they’re my eyes and ears”(Rosenberg et al., 2007, p. 290). Though they may not reveal everything, for instance in a case of abuse, this study shows:

One physician remarked that by simply observing interactions between patient and family member interpreter, much could be learned regarding the patient's lifeworld: ... What is interesting with the family member is you learn about the family dynamics. You learn more about the natural setting of the patient; you cannot learn this from the [professional] interpreter. You see him with her and how they are reacting and you have his input and you see how he's thinking. (Rosenberg et al., 2007, p. 290)

The familial interpreter may reveal more information than the patient would have given, which can drastically improve the diagnosis or treatment process for the doctor. Additional insight could include whether the patient is following through with treatment plans, experiencing behaviors they may be unaware of, or bad habits they would prefer to keep secret.

Bringing a child to appointments may seem like an all-around beneficial idea to the parent. Though not the case for all LEP parents, it is possible that adolescent healthcare brokers are used out of availability in families from lower socioeconomic backgrounds who may not have access to affordable childcare or time to spare waiting on a qualified interpreter if they are burdened by potentially multiple low wage jobs. Having a child with a working knowledge of English attend appointments can ease the financial and emotional stress for many families.

Drawbacks of Adolescent Healthcare Brokering

Though adolescent healthcare brokering may seem like the best option for the efficiency of doctor-patient interactions, there are strong consequences that this may have on the adolescent interpreters involved. If severe enough and without proper support, the broker may be left with long-lasting trauma and developmental setbacks. The biases that an adolescent healthcare broker may bring to an appointment, along with their developmental capacity and linguistic capabilities, pose grave risks to the health and wellbeing of all involved, especially under traumatic circumstances.

Though there is a benefit to the personal insight a familial interpreter can provide, there is a thin line drawn between patient and interpreter advocacy. The immense power the adolescent healthcare broker has over the conversation between the doctor and patient is often taken advantage of when the interpreter consciously or subconsciously influences the discussion with their own bias or personal agenda. Because they are in the position of power over the patient, often a parent, “this possibility for intervention makes interpreting attractive for family members: they get the opportunity to become part of the treatment process, and ultimately influence the patient’s decision-making” (Meyer et al., 2010, p. 314). While often only abused for the perceived benefit of the patient, this power dynamic tends to leave out the patient almost entirely from the conversation. In a study on doctor-patient interactions, researchers found that “physicians commonly complained that the family interpreter answered for the patient without translating the physician's question, transmitting his or her own perceptions, as interlocutor, and not transmitting the patient's perceptions;” in this case, the doctor explained, “it was the husband who translated and I found sometimes, when I asked something, he didn’t even ask his wife what she wanted to do. He just answered me, without asking the patient” (Rosenberg et al., 2007,

289). Without consulting the patient, the husband made his own decision regarding her care; though this example is between adults, the familial interpreter interaction occurs similarly with children.

In another doctor-patient conversation, a child is interpreting for his parent and similarly pushes his own agenda instead of what the doctor is suggesting:

The son uses his role as an interpreter to criticise the eating habits of his father, who has not been following his diet, and explicitly complains in Turkish about the small portions of food he gets in the hospital... Rather, the son selects those bits of information that can be used to his advantage in the argument between him and his father. While the dietician provides diet information in a neutral and objective manner, the son argues with his father and tries to convince him to follow diet instructions. The neutral tone of the dietician is changed into a personalized type of discourse, full of references to previous talks, the specific eating habits of the patient and his lay perceptions of diet.” (Meyer et al., 2010, 314).

In the original source, the son believes that his father is eating too much pasta and needs to cut it completely from his diet. Though the dietician is explaining ways to make the rest of his diet healthier and still include smaller portions of pasta, the son relays to his father that he will make his diabetes worse if he continues eating pasta, without mentioning the dietitian's compromise. Despite no direct harm done to the patient, the familial healthcare broker promotes his own advice over that of the certified dietician.

As the name suggests, adolescent healthcare brokers have yet to reach the critical developmental stages in which their brains are fully formed and they are considered adults. Adolescent healthcare brokering inverts the parent-child roles by forcing the child to be directly involved with the care and wellbeing of their parent. This role reversal causes children to mature faster than they are prepared for developmentally. Because many adolescent healthcare brokers begin their interpreting jobs from a young age, researcher Castañeda (1998) asks, “what cultural rites are these in which children become adults long before puberty?” (p. 230). When children

are pushed beyond their maturity level, they often lack the mental capacity to fully grasp and understand the concepts, especially surrounding their parent's health. As quoted in *The New York Times*, Dr. Alice Chen of San Francisco General Hospital said "'I've seen kids who walk away thinking they caused it'" (The Associated Press, 2005). Similarly, while translating for her mother at a hospital, a child expressed "I do not have the words to help her. She will die...She called me her *lengua*, her *voz*. If she dies, it would be my fault" (Castañeda, 1998, p. 230). Because adolescents are transitioning from Jean Piaget's stages of concrete operational to formal operational thought, they may have yet to grasp the abstract concepts of medical causation, leading them to detrimental false understanding that they were the reason their parent was sick or died (McLeod, 2018). This type of developmental misunderstanding and forced maturity can have detrimental effects on the overall health and wellbeing of the child involved.

Initially, it may be easier to have a child interpret a regular doctor's appointment for their parent. However, if there are more serious health conditions or medications required, the job of the adolescent healthcare broker becomes much more vital. Researcher Castañeda (1998) poses some thought-provoking questions regarding the unique experiences brokers face:

What rites of passage are these that require children to conceive the significance of, construe, and interpret entire cultural universes for adults, universes that include every possible human experience: from a nation's mythology and ideology, a sibling's arrest, pregnancy and pre- and post-natal care, an argument with a boss who refuses to pay the wages he agreed to pay? What rites are these in which childhood's boundaries are transgressed each time a child is required to translate - and thus mediate, negotiate and broker adult realities across cultures? (p. 233)

Though the intensity of the situation may be stressful already, the broker often needs to navigate the interaction flawlessly to avoid detrimental effects, especially when it comes to healthcare management. The *New York Times* shared the story of a 12-year-old healthcare broker serving for his Hmong-speaking mother who "began taking her medication in the doses her son

described, but soon felt so dizzy she could not get out of bed for two days...[He] had mistranslated the doctor's orders, leading his mother to take the wrong dosage” (The Associated Press, 2005). An adolescent healthcare broker should not be expected to have perfect bilingual fluency, especially under stressful and imperative situations, and such expectations can lead to grave miscommunications. Researcher Castañeda (1998) reflects on interviews and her own experiences as a broker:

Panic. What does that word mean? How do I say panic? How does a seven-year-old girl, not yet in the second grade, translate the life and death words “atora,” “suffocate,” “resollar,” “panic?” How does she explain and interpret words she does not know in either language, while knowing at the same time that her mother’s life sits on her tongue and on what she does with the words given her? Where in her seven-year-old knowledge does she find the meaning of words that hold the life or death of the mother who calls her ‘mi lengua’ - her tongue - the fleshy, movable organ attached to the floor of the mouth with which words are made? (p. 230)

This excerpt reflects the emotion behind the catch-22 situation children feel obligated to manage, as they struggle with the medical interpretation and perceived responsibility over their parents’ lives. Additionally, if brokers do not relay the same severity of words that the doctor used, they risk interpreting a less urgent version of the message. This may lead to a patient not thinking their condition is as critical as it is or not taking the physician’s advice as seriously as they are intended to.

Though physicians receive specific training and have access to hundreds of books on breaking bad news to patients and their families, adolescent healthcare brokers are often the ones responsible for hearing the news first and then having to inform their loved ones. When the physician uses various grief-management tactics to deliver the news, they not only have the tools to manage the conversation but have a professional, working relationship with the family. Adolescent healthcare brokers are already exposed to potential trauma depending on the outcome and severity of the case; lacking the proper tools and training to discuss life-threatening illnesses

or losses can only add to the existing stress. Parents often seek guidance on discussing death, dying and serious illness with their children, proving that it is a difficult conversation for adults to have with a child. Adolescent healthcare brokering inverts the traditional parent-child relationship and Castañeda reflected upon the result (1998) as followed:

The act of translation is informed by unequal power relationships. Translation usually occurs under conditions of conflict and stress. It is frequently traumatic, and the trauma is long-lasting. Children are often at the center of the process of translation, and they experience that trauma more strongly than adults. What, then, do we make of children translating cultures? How do we assess, analyze, theorize, and interpret this experience, which in most cases continues into their own adulthood and generally until their parents' death? (p. 236)

It is assumed that adolescent healthcare brokers receive the same support as other non-brokering family members would in the parallel monolingual situation; pamphlets or support groups may be made available to help manage the emotions surrounding a difficult diagnosis or loss.

However, the brokers that are responsible for delivering bad news or enduring a traumatic interpretation would most likely need additional, specialized, stronger resources catered to their unique experiences. This is just one of many tools that would ease the permanent damage that may result from traumatic brokering.

Furthering the Discussion of Adolescent Healthcare Brokering

Research has consistently revealed that adolescent healthcare brokering is often detrimental for the academic, mental, emotional and social wellbeing. Brokers may benefit from exposure to the workings of the medical field and positive relationships with healthcare professionals, but those do not outweigh the potential damage of healthcare brokering. As stated by researchers Kam and Lazarevic (2013), "language brokering remains prevalent among immigrant families, but it is widely assumed that brokering functions as a cultural stressor, resulting in adverse health outcomes for immigrant youth" (p. 1994). The continued use of

linguistic and cultural brokers despite the detrimental effects proves the need to pursue further research and advocacy for immigrant communities.

Prevalence of Adolescent Healthcare Brokering

The terms “adolescent healthcare brokering” and “child language brokering” are relatively new but the overall practice had been occurring in some form or another for centuries alongside immigration. A crucial connection I made through my review of existing literature and studies was that this is not a phenomenon unique to the United States. Adolescent healthcare brokering is occurring internationally, often revealing similar experiences and research findings. Though the laws surrounding the practice, languages spoken and origins of immigration may differ, it is important to acknowledge that adolescent healthcare brokering is a worldwide issue affecting all children involved similarly.

Importance of Perspectives

For future research on adolescent healthcare brokering, it is crucial to obtain a reflective and representative understanding of the phenomenon from every possible perspective involved. The existing research is heavily reliant on the experiences of the children directly involved in the translations, with many also bringing in the medical professionals into the mix. However, often left out of the conversation are the voices of the parents and siblings of the brokers. By studying all involved in healthcare brokering, researchers can better find potential solutions to improve doctor-patient communication. Including as many different cultures and language minorities as possible would continue to show the depth of this phenomenon and proving that it isn't confined to just one culture, country or language.

Potential Strategies for Implementation

Adolescent healthcare brokers experience many situations from which natural-born children of the same age are usually shielded; if a doctor would not request the same from a child of the same age whose parents do not need an interpreter, why is it acceptable for immigrant children? Because “the language one’s family speaks should not have to be an obstacle to optimal health,” institutions must implement changes to stop the discrimination and exploitation of immigrant children (Banas et al., 2016, p. 904). The following implications for healthcare and academic providers should guide the shift away from violating the rights of immigrant children and families.

Increasing Enforcement

As this paper previously presented, there are numerous laws making the use of children as interpreters illegal. However, as also mentioned, child language and healthcare brokering is still occurring at the same, if not accelerated, pace. In terms of discontinuing this practice, the seemingly simple solution would be to enforce the existing laws, potentially creating ramifications for those who still wish to break them. Because there are no established consequences, these laws seem trivial and insignificant, almost as if they were written out of obligation instead of concern for the wellbeing and safety of those involved. Increasing the enforcement and inducing higher stakes for these laws may hopefully reduce the use of brokers to only emergency situations as the laws describe.

Increasing Education

It is entirely possible that the reason for perpetual child language brokering is that it is either seen as an “immigrant issue” or unknown because of such views. For dominant natural born citizens, many may never come across child language brokering or may not realize the

unintended harm it causes. Personally, I had passively seen classmates translating for their parents, but didn't recognize the intensity or issues it caused until very recently when one of my mother's students revealed the overwhelming stress caused by acting as an adolescent healthcare broker.

Another way to decrease the occurrence of adolescent healthcare brokering would be increasing the awareness about the legislation, specifically in medical and immigrant communities. It is crucial that both groups know about the legal rights to professional interpreters so they can self-advocate or advocate for those directly involved. If medical professionals were to learn about adolescent healthcare brokering and the associated laws in depth during training, they may be more willing to promote the use of certified interpreters or at least educate patients about their rights. Though the laws in the United States require most facilities to post notices in the top languages notifying patients about their rights to a professional interpreter, increasing the availability of these notices and providing more bilingual resources would allow patients to be better informed; doing so may make patients feel more comfortable requesting services and confident that they will be fulfilled because the frequency of availability makes the medical office seem more accommodating and approachable. Because of the existing power dynamics between both the doctor versus patient and natural-born versus immigrant relationships, some immigrant families may not feel comfortable speaking up and requesting a professional interpreter, especially if their healthcare provider seems intimidating or inconvenienced. By empowering all parties involved in the brokering process, there will be more confidence in exercising the legal right to professional interpreters. As exemplified below, familiarity paves the way for such empowerment:

In isolation, low health literacy and LEP pose significant barriers to effectively participating in one's healthcare, but together the effects are magnified. As one becomes

more fluent in the language and the way health communications are presented, one is more likely to seek healthcare treatment, and take an active role in gaining access to and using information in ways that promote and maintain good health. (Banas et al., 2016, pg. 898)

With the inclusion of legal rights into the presentation of health communications, patients may be more likely to break the long-standing trend of using children as interpreters. Additionally, through educating the larger society about the existence, prevalence and consequences of this phenomenon, friends or natural born community members could use their privileges as members of the dominant group and serve as indirect advocates or allies in fighting for the implementation of these existing rights.

Increasing Broker Support

In case the previous suggestions are not enacted or the phenomenon continues, there need to be support systems implemented concurrently for the children and families who remain trapped in the brokering lifestyle. Immigration has proven stressful enough on children and that stress is only exacerbated by the participation in linguistic and cultural brokering. When children perform what many see as a normal family duty, they are less likely to seek assistance and assume their friends are experiencing similar. Based on a survey given to high school healthcare brokers, researchers found that 80% were interested in receiving additional support; while forming in-person support groups was less desired, many “wanted a website to ask questions and receive answers about healthcare tasks (32.9%), to obtain healthcare information in English and their family’s language (29.5%), or to read information or watch videos about healthcare tasks (21.2%)” (Banas et al., 2016, p. 901). This data reflects the wishes of a select population of United States healthcare brokers and can be used as a launching pad for the creation of tools to support students worldwide.

Through connecting healthcare brokers in face-to-face or virtual support groups, they would be given an opportunity to empathize with or share resources with others who share similar experiences. Increasing the conversations around adolescent healthcare and child language brokering in general between school staff and students and between students will provide a safe space for students to discuss it, therefore helping them relieve stress and see the gravity of their work.

Expanding the health education to include learning about healthcare management and performing tasks will benefit all students, regardless of if they work as an adolescent healthcare broker or not. Teaching students real-world skills will give them an advantage over many young adults who have to learn to navigate their healthcare experiences with little to no guidance. As schools increase support and resources for brokers, they establish themselves as a reliable, safe space for those struggling, which in turn may increase the students' academic and emotional success. Since adolescent healthcare brokering has continued to occur despite breaking multiple laws, schools might as well work with the phenomenon to provide valuable and unique medical experience to students.

Increasing Interpreting Services

Many solutions are dependent on the integral availability of professional interpreters. Though translation services may be available over the phone, they are unable to integrate the non-verbal communication or cultural interactions that would be possible in-person. Shortages of medical interpreters can prove problematic, as it becomes increasingly more tempting to use children in their place. To become a certified medical interpreter, an adult must be able to prove linguistic proficiency in two languages and undergo a 40-hour training program before passing both oral and written certification exams administered by The National Board of Certification for

Medical Interpreters. Issues then lie within the payment for hired interpreters; though much more complex, this could be worked out by federal or institutional funding, grants, non-profits, donations or pro-bono work placing the priority on ending the exploitation of immigrant children and families.

Standardized practices and guidelines for working with both professional and familial interpreters must be established and added to existing medical training. The techniques healthcare providers employ should be sensitive to the type of interpreter present and conscious of the addition of a third player to the traditional doctor-patient interaction, focusing on the consistent inclusion of the patient while potentially acknowledging the role of interpreter as a family member or health witness.

Increasing Screening Content

For many adolescent healthcare brokers, they cannot watch rated R movies but are expected to give terminal diagnoses and interpret in traumatic situations, both of which are arguably more terrifying than the content of most films. By creating a standardized set of guidelines influenced by developmental understanding and processing, doctors have a predetermined list of scenarios that would be deemed inappropriate to use an adolescent healthcare broker. These must be consistent with the expectations for native-speaking children in the same age group, given they were expected to play the same role in a monolingual doctor-patient interaction, while remaining sensitive to the sociocultural norms of both the country of residence and origin of the interpreter.

For a routine check-up on a typically healthy adult, it may be appropriate to use a child for translation purposes if requested. Reproductive health visits would be deemed inappropriate if the parent and interpreter have opposite gender identities, especially if the child is older.

Excluded from all lists should be interpreting moderate to severe diagnoses as regardless of age, these would be traumatic for any family member to deliver. Though not a perfect solution, screening content may prevent the adolescent healthcare broker from incurring further trauma.

Conclusion

Upon recent immigration to a new country, parents may find it necessary to use their children as translators to help overcome potential language barriers. Because of the efficiency and ease of child language brokering, it often decreases or completely eradicates the need for the parent to learn the language at all. Thus, linguistic and cultural brokering occurs across many platforms, many of which may seem harmless; however, many consequences may arise when children act as healthcare brokers.

The purpose of this paper is to synthesize existing literature surrounding both child language and adolescent healthcare brokering to analyze the benefits and drawbacks to each before diving deeper into the medical phenomenon specifically. Findings reveal that despite laws in some countries established to prevent it, adolescent healthcare brokering is continuing within immigrant communities and is occurring with similar results worldwide. The results of many previous studies show that while there are some positive aspects to acting as a broker, the negative impacts are far more severe. Lastly, suggested solutions informed by the frequent experiences of those studied in preceding research are provided.

In order to protect the adolescent healthcare brokers and better serve immigrant communities, there are many different stakeholders that can influence change, including lawmakers, doctors, patients, allies and adolescent healthcare brokers themselves. Further research regarding adolescent healthcare brokering is encouraged to continue revealing its impact, seeking desired support and developing more implications to hopefully fully tackle this

unique phenomenon. As the field of linguistic and cultural brokering gains traction, I look forward a future in which healthcare professionals are no longer inadvertently exploiting and violating the rights of immigrant children.

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